Medicaid Eligibility Reporting Period and Calculation options

Medicaid Eligibility Requirements:	To be eligible for the Medicaid EHR Incentive Program, providers must meet a minimum percentage threshold of Medicaid patient. • 30% minimum Medicaid encounters • 20% minimum for Pediatricians (at a reduced payment). • All providers that meet or exceed 30% receive the full payment.
Reporting Period for Medicaid Eligibility Calculation:	Any consecutive 90 days from the previous calendar year or a consecutive 90 day period prior to the submission of application for the program year. • The 90 day period does **not** have to begin on the first day of a month The Medicaid eligibility reporting period does **not** have to match the reporting period for an individual provider's meaningful use reporting period. They are two different reporting periods.

Methods for developing the Medicaid Eligibility calculation

1. **Individual provider method:**
   - **Numerator**: One provider's Medicaid patient encounters for a 90 day period
   - **Denominator**: Total number of all patient encounters in the same 90 day period.

Example: Dr. A had 89 Medicaid patient encounters and a total of 200 patient encounters (the 89 Medicaid encounters are included in the 200 total count) for January through March. The calculation is 89 divided by 200 = 0.45, 0.45 equals 45%. Dr. A has a 45% Medicaid Encounter rate for the 90 day period.
Please note: If an individual works in a practice setting and uses their individual encounter numbers for their Medicaid eligibility calculation then all providers at that practice site must use the individual method if they are applying for the Medicaid incentive program.

2. **Practice/Group level encounters: (FQHC/RHC/IHS may add reduced fee and no fee claims for a "Needy" calculation)**
   - **Numerator**: All Medicaid/Needy patient encounters for a 90 day period
   - **Denominator**: Total number of all patient encounters in the same 90 day period.

Note: To group encounter numbers together for a practice or multiple practices the three conditions below must be met:

1. The clinic or group practice(s) patient volume is appropriate as a patient volume methodology calculation for the EP; and
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).
   - If you choose to report at the practice/group level you must use the **entire** practice/group patient volume and not limit it in any way.

- If an EP works in both the practice/group and outside the practice/group then the practice/group level determination includes only those encounters associated with the practice/group; the resulting Medicaid eligibility calculation will be used by all providers in the practice/group applying for the Medicaid Incentive Program for the program year.

Important: FQHC'S PLEASE NOTE 2015 documentation change:

We have previously accepted the data from a UDS Table 4 Report for the documentation of Needy eligibility. We have been informed this is not adequate documentation for a post payment audit as the UDS table 4 includes only unique patient encounter counts over a full calendar year. Beginning program year 2015 you will be required to calculate the needy calculation with documentation of patient encounters for a 90 day period as described above.

Documentation to maintain:

- You may use your billing/claims system as well as other sources to accurately calculate your percentage.
- You must retain all documentation for a minimum of six (6) years for all submitted information to the Medicaid EHR Incentive Program:
  - 1) The source of your information
  - 2) The 90 day period selected
  - 3) How the Medicaid eligibility calculation was developed - Individual provider or Practice/Group level
  - 4) If utilizing the Practice/Group proxy methodology, the submitting entity should be able to document that all encounters associated with all group members have been included in the calculation; not only the providers participating in the Medicaid Incentive program.
  - 5) Detailed information to validate patient eligibility must include:
    - Patient name, Medicaid member ID number, if applicable, date of service, payer source, payment amount, and servicing physician
    - You will need detailed patient level data to document how a patient encounter was identified as a Medicaid patient, or a different insurance type. We are required to validate your documentation.
    - It is optional to submit the detailed documentation with this worksheet but it will be mandatory for an audit.
- **Important: FQHC/RHC Providers**: Additional requirement
  - All providers practicing at an FQHC/RHC must meet the definition of "practice predominantly"
  - **Practices predominantly**, means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year or the preceding 12 month period prior to this application occurs at a FQHC or RHC.
  - If a provider has not worked at an FQHC/RHC for 6 months you should wait to apply when they meet the practices predominantly definition.